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The Side Effects of Topical Application of Corticosteroids to the Eye

By Robert E. Krol
First Year Student

Corticosteroid drugs are pharmaceutical preparations which are non-specific in nature and have an anti-inflammatory effect in allergic, traumatic or infectious etiologies. It is important to realize that even though the body's inflammatory response is prohibited by steroids, the infectious or allergic cause is not eliminated and therefore continues to be present. These drugs are used to treat a number of both local and systematic anomalies such as rheumatoid arthritis, bronchial asthma, Still's disease and gout. Corticosteroid treatment is often directed to the eye to alleviate inflammation and scarring that might otherwise result in functional damage to this delicate structure. It's success in reducing scarring and saving useful vision has been applauded since it's advent on the medical scene. But, it's shortcomings, in the form of deleterious side effects, are salient enough to receive a share of the publicity.

THE INAUGURATION OF CORTICOSTEROIDS

Before the introduction of corticosteroids, their synthetic derivatives and adrenocorticotropic hormone (ACTH), similar although less intense effects were evoked by means of injection of foreign proteins or anterior chamber paracentesis. It is believed that pituitary production of ACTH was stimulated by fever therapy induced by foreign protein injection.[1] With the discovery of cortisone and other steroids, begun by Hench and his colleagues in 1949, it became possible to obtain the desirable fever therapy effects without the customary unpleasant and sometimes dangerous fever and generalized illness. Few new medicines with the exception of some antibiotics have had such a powerful impact on the medical-pharmaceutical world and have been able to achieve such frequent and widespread use as the corticosteroids.[2] Their overwhelming usefulness has caused a continuing rise in the production and consumption of corticosteroids in spite of the early recognition of the threat of serious side effects. In the last decade, the literature has revealed these imperfections to an extent not previously realized. But, being still a relatively new drug, investigation of the effects of steroids is far from complete. The biological mechanisms whereby steroids reduce inflammation are not well established, let alone the intricacies by which toxic side effects are incorporated into the picture. However, regardless of these unknown physiological processes, the outward manifestations of various side effects do occur and must be attended to.

TOPICAL APPLICATION OF CORTICOSTEROIDS TO THE EYE

What has just been said applies to steroid use in general. But, it must be pointed out that many steroid drugs are available and the properties of each may differ somewhat in spectrum and intensity. Some of the newer corticosteroids, in fact, may be indicated to reduce the proportionate risk of side effects but indeed none has eliminated them. Furthermore, there are three basic methods of administration of corticosteroid therapy: systematic injection, oral consumption and topical application. These different routes of entry significantly effect the type and extent of side effects produced. From this point onward all reference to steroid application in this article will refer to topical administration of corticosteroids to the area of the eye unless otherwise specified. The side effects of topical administration are usually the least severe and are rarely systematic but they are fairly common to the eye care field and will serve to demonstrate the point of this article.

Topical application of steroids to the eye has been implicated with increasing intraocular pressure (even to glaucoma), formation of posterior subcapsular cataracts, reduction in resistance of the body to infection, increasing susceptibility to fungus infection, transient myopia and mydriasis. Whereas, many authorities accept and even proclaim a cause-effect relationship of all or some of the above symptoms to corticosteroids, many are confident that other factors are responsible. For reasons which will soon be designated, the results of re-

cent experimentation and the correlation of clinical evidence often appear to be inconsistent and inconclusive.

PROBLEMS INHERENT IN INVESTIGATING STEROID SIDE EFFECTS

To cite an analogy, for years investigators have been struggling to determine the relationship between cigarette smoking and lung disease. Obviously, not all smokers suffer lung disease and extensive studies were necessary involving the effect of cigarette smoke on the lungs as a function of the age of the smoker, amount smoked, duration of smoking etc. These experiments were successful insofar as localizing the risks involved with smoking. For example, today it can be said with authority that twenty-five to thirty percent of 'heavy' smokers will suffer lung anomalies attributable to smoking. The problem in determining the relationship of steroid application to its proposed side effects is similar to this smoking — lung disease example but there is one big difference. The difference is that corticosteroids are used to treat existing diseases of the eye. Hence some doctors believe that the reason for the supposed side effect (such as cataract formation) is due to the physiological condition of the patient which warranted steroid use and not the drug. On the other hand, cigarette smoking is not used for any reason involving the existing condition of the lungs.

There exists a real problem in nailing down the relationship between corticosteroid therapy and various ensuing anomalies. This author believes that the main reasons are:

1. Many factors described below involving the individual drug and its administration relate to its effect on the body. A variety of such combinations are possible, injecting a number of variables into any given situation. These are the variables: the specific type of drug used, the quantity used, the concentration of the drug, its pharmaceutical preparation such as liquid or ointment, the duration of time the drug is used, its daily frequency of application, its method of application (topical, oral, systematic), and lastly the care of the patient in applying the drug to the proper area and in quantities prescribed by the physician.
2. Each individual has unique physiological characteristics that alter the drug's effect on them. For example, innumerable hereditary factors, acquired allergies, infections and diseases present in the patient may very likely effect his reaction to the corticosteroid therapy. Furthermore, the type and severity of the specific problem being treated with steroids, the age of onset and the age of treatment of symptoms, present age of patient, sanitary and nutritional conditions of patient and other drugs which the patient may be using in conjunction with or separated from the steroid may influence the body's response.
3. Doing significant experimental research on human subjects is difficult and often out of the question since the health of the patient is at stake. Shadows have been cast upon correlating case histories or reports from clinical files for the first two reasons given in this section. Animal studies have a very limited usefulness due to obvious physiological differences.

CASE HISTORY

The following is an original, unpublished but abbreviated case history of a twenty-five year old pharmacist who developed cataracts at age nineteen. It will serve to demonstrate the inherent difficulty that exists in attempting to diagnose the possible relationship of topical corticosteroid treatment to cataract formation.

When eight years of age, the patient suffered from severe allergic conjunctivitus which responded to periodic topical application of the corticosteroid, metreton. At age seventeen, the patient was being treated for multiple allergies, an atopic eczematous condition and a considerable bilateral chronic squamous blepharoconjunctivitis. Another corticosteroid, topically applied hydrocortisone combined with blephamide liquifilm and achromycin, was prescribed. At age eighteen, for a period of three months, metymid and achromycin ophthalmic drops were prescribed and the patient's eyes became a deep red and bloodshot during this time. The redness cleared up after disuse of the steroid preparation. Treatment with a previously mentioned steroid was continued. Dosages in all cases were moderate to high and the patient admits frequent overuse of the drugs due to the severity of his condition. At age nineteen, posterior subcapsular cataracts began develop-

ing in both eyes. The doctor believed that the etiology was due to the atopic condition of the patient but he discontinued prescribing corticosteroid therapy as soon as posterior cortical lens changes were observed. The cataracts matured in both eyes and the left eye was operated on for lens removal successfully. The right eye developed a chronic staphylococcus infection which has been resistant to all antibiotics used in a three year period.

What really caused the posterior subcapsular cataracts? It may be the atopic dermatogenic skin condition of the patient. The lens, after all, is composed of epithelial fibers. The corticosteroid may be the precipitating cause either in itself or because of its use in conjunction with other drugs employed to alleviate related problems. Furthermore, the chronic staph. infection could be a function of the body's reduced resistance due to steroid therapy. Certainly, these speculations are difficult to prove as many factors are interrelated.

BASIC DESIGN FOR STEROID USE

In spite of the problems with corticosteroid — side effect research and amidst conflicting reports from various sources, some very important guidelines have emerged. Indications are that steroids should be used in high dosages only when absolutely necessary. Most presumed side effects are connected with high dosages. Furthermore, studies on the ocular penetration of topical application of steroids indicate that there is no need for massive dosages since it does not proportionately increase the amount of drug absorbed. It follows that dosages should vary according to the severity of the disease. In regard to the concentration and strength of various drugs, it appears that the desired response to topically applied steroids seems to require about the same initial amount or concentration no matter which drug is used. The stronger drugs seem to be more potent because of their slower rate of destruction within the body. Studies show that, usually, increased frequency of application is more effective than a stronger concentration. Also, the duration of time over which the drug is taken seems to have a strong influence on the occurrence of ensuing problems. Some research on cataract formation, for example, indicates that a minimum duration of one year is usually required at 'moderate' to 'high' steroid use for the formation of steroid-induced cataracts to occur.

IMPORTANCE OF JUDICIOUS USE OF STEROIDS

Some patients have serious problems that necessitate extensive use of corticosteroids. Without the corticosteroids, perhaps, ocular inflammation and scarring would cause blindness. In such a case, if resistance to ocular infection or even cataracts developed, the patient may still have benefited overall from the therapy. But, consider the even more tragic case of the patient who uses corticosteroids for mild eye irritation or hay fever and as a supposed result of the drug use suffers a permanent visual loss.

In a report by Doctors Ronald M. Burde and Bernard Becker, the indiscriminate topical application of corticosteroids to the eyes of two young patients was implicated in inducing cataracts and glaucoma with permanent visual defects. In one case, a seventeen year old girl was experiencing discomfort while adjusting to contact lenses. A corticosteroid preparation containing prednisolone acetate was prescribed with one drop daily in each eye. Sixteen months later blurring of vision occurred. Three months still later, elevated intraocular pressure and the formation of posterior subcapsular cataracts were reported with severe accompanying visual field loss. Questioning of the patient revealed that, without the knowledge of her physician, she had renewed the original prescription and continued to administer at least one drop of the steroid every day.[1] Therefore, this demonstrates the necessity of the patient knowing the complications of every drug that is used.

Another example of the potential danger in indiscriminate steroid usage is illustrated by the tragedy of a fifteen year old boy who used prednisolone drops several times a day for hay fever. When first seen by the ophthalmologist, the boy had advanced glaucomatous cupping, 20/70 vision, a pressure of fifty millemeters Hg. and a field loss to within five degrees at fixation. This irreversible damage apparently occurred during a six month period.[1]

SUMMARY

When properly used, steroid application to the eye will markedly reduce the amount of inflammation and scarring and may make the difference between useful sight and blindness. Their availability and usefulness make these drugs a remarkable asset to opthalmological treatment. But, sufficient accusations have been

made which tie these drugs in with very serious side effects. At least until more is learned, the benefits and past laurels of steroid use should not blind us to their suspected pitfalls. This article attempts to bring to light the need for judicious use of steroids. What this paper proposes to offer is not original data or conclusive inside information. Instead it offers exposure and recognition of a serious ocular problem, a list of references in which to find more detailed and original information, one personal case history report from a possible steroid-induced cataract victim, and an overview of the present knowledge on this subject. The author has not attempted to criticize the eye care practitioner but rather only exemplify one more factor which must be mixed and blended with several other weighty considerations in the diagnosis and treatment of certain ocular disease.

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MARINERS

In this measured space, bounded
by time and mind, we sail to
darkness
or to light; not knowing whether
Universe is curved or flat.

What unknown metric have we
here?
What coordinates can mark
a point of view or steer a course
of reason when the stars are gone?

Eugene A. Craig

Wellesley, Mass.

Faculty Member M.C.O.

Boston Student Health Manpower Conference

On March 11-12, 1972, a group of health professional students assembled in Chicago for a landmark National Student Health Manpower Conference. It was funded by the National Institutes of Health and designed to promote better interprofessional understanding and cooperation.

Towards realization of their goals, NIH awarded a grant to the Student American Pharmaceutical Association for this current year to subcontract a minimum of 10 regional health manpower conferences. Any professional school could take the initiative in their region and submit a proposal.

The American Optometric Student Association had set optometric student involvement in these conferences as one of its goals for this year. This goal has been more than met.

A proposal for the Boston Region was formulated and submitted with strong support from all the professions. It was selected as the second best formulated nationwide and was funded to the extent of $4,958.00. The Project Director and primary author of the proposal was Thomas Freddo, a first year student at MCO.

The Conference was held on the weekend of April 27-29 at The Harvard Club of Boston.

It included students and faculty from every health professional school in the Boston Region. The professions represented were Medicine, Dentistry, Osteopathy, Podiatry, Nursing, Public Health Pharmacy, Social Work, Clinical Psychology, Veterinary Medicine, and of course Optometry.

Others in attendene were state professional society representatives, local Directors of Public Health, consumer representatives, and neighborhood clinic directors.

The keynote speakers were Derrick Robinson, M.D. PhD., Director of Community Operations; Massachusetts Department of Public Health, who spoke on "Future Activity of Federal and State Government in Health Care" and Mr. Melvin Scovell, newly appointed state director of Medicaid who spoke on, "Health Care: Students and Community."

The four major topics dealt with by the Conference were:

> Interdisciplinary Awareness and Changes in Health Care under Federal Health Legislation
>
> Recruitment and Retention of Minorities and Women in the Health Professions
>
> Use of Health Professional Students as Community Resource Units and as Consumer Educators
>
> Formation of a Permanent Interdisciplinary Boston Health Student Alliance

One of the major long range goals of the Conference is establishment of an interdisciplinary student clinic where joint clinical training and case history discussions could be held. The purpose herein would be to give each student clinician a better feel for the true potential of each of his health team colleagues.

Joint Efforts In Minority Recruitment

By Henry J. Parker, J.B.S.
First Year Student

Like all other health professions, optometry has a severe shortage of minorities. In an effort to recruit more Blacks, Spanish-Speaking, and other minorities, many shcools and organizations have developed various ways of presenting optometry to prospective students and the community.

Methods such as using brochures, films, and personal contact (one-on-one) have been employed. By not having the statistical results of how many students might have been recruited by either of these methods, it is impossible to assess how effective is any method of recruitment. However, more effective means must be developed by which the Black community can be educated about the importance of vision care, and especially, getting the under-privileged student interested in the field of optometry.

Optometry must be viewed by the public with the same importance as medicine, dentistry, and other health professions. It has been my experience to talk with people who have absolutely no idea of what optometry is. I have talked to others who have heard of and seen an optometrist, but until my conversation with them, they thought an optometrist was one who obtained a B.S. or M.S. degree, and his function was simply to fit glasses. Still, others do not see optometry as a health profession, but rather a craft which anyone could do with a just a few years of training.

My profound interest in recruiting Blacks and other members of the minority group lead me to seek new and more effective means of recruiting and informing the community about vision care. As a result of these activities, a meaningful, collaborative relationship was developed between the Massachusetts College of Optometry (MCO) and the Roxbury Medical-Technical Institute, Inc. (RMTI).

I was first informed of RMTI through an article which appeared in the Boston Globe newspaper, dated December 22, 1972. This article made mention of how RMTI prepared students from the Black and minority communities for entering medicine, dentistry, and other health professions, but not optometry. After talking with Mr. Shearer, President, and Mr. Octavius Rowe, Founder and Executive Administrator of RMTI, I found that very few knew about the existence of MCO, and they were, of course, very disturbed to learn of the tremendous shortage of Black optometrists in this country.

Roxbury Medical-Technical Institute is situated in the heart of Boston's Black community. It has ready access to the main system of city transportation so students from all over Greater Boston can have convenient transportation. The primary purpose of the Institute is to increase the representation of Black and Spanish speaking people in the health professions in the Greater Boston communities. They have set out to do this by giving a firm education to disadvantaged youths in grades 3 through 12, and pre-college. A significant aspect of this educational thrust comes through the exposure of these youths to minority medical and health professional role models who, in turn, play a paramount part in helping to motivate students to pursue a career in one of the health professions. RMTI recognizes the financial problem which has always been a contributing factor for the high attrition rate among Blacks in professional schools. They have committed themselves to supplying their students with information which will inform them of ways in which to secure financial assistance, thereby encouraging more minorities to enter the medical, dental, optometry, and the allied health professions.

The Institute has set as its goals, the following:

1. Improve the child's picture of himself, giving him frequent opportunities to succeed and avoid failure through his own efforts.
2. Develop a good relationship with our peers as we learn to give, and later as we work and build.
3. Broaden the child's world and increase his career mobility by providing wider and more varied experiences.

4. Encourage the idea that a learning environment is a great place in which to be.
5. Involve parents as much as possible in the total program.
6. Improve each child's health through an internal program of regular medical-optometric, and dental examinations and treatment.
7. Provide a basic knowledge of nutrition and hygiene.
8. Assist in the total physical, social, emotional and intellectual development of the child.
9. Involve the community at large in some way by providing public health services like ambulances, first aid stations, and others.
10. Help the child and his family build greater confidence, self respect and dignity.
11. Develop in the child and his family a responsible attitude towards society and a feeling of belonging to the community.

The Institute also has a program for students (Pre-College) who wish to prepare themselves for matriculation in a medical or health professional school.

After looking at the purpose, goals, and success of RMTI after only two years of existence, it appeared to me that this is the most effective method of educating the Black students and community about optometry, and encouraging minority children to enter optometry as well as medicine and dentistry.

The next step was to introduce the administrative personnel of RMTI to those of The Massachusetts College of Optometry with the intent of establishing a meaningful collaborative relationship between the two institutions and to encourage RMTI to incorporate in its programs courses which would further prepare students for entering the field of optometry just as RMTI has done for medicine, dentistry, and other allied health professions.

Starting the first of the year, 1973, several meetings culminated with the discussion of several topics which, if materialized, will be of mutual benefit to both institutions. These topics included:

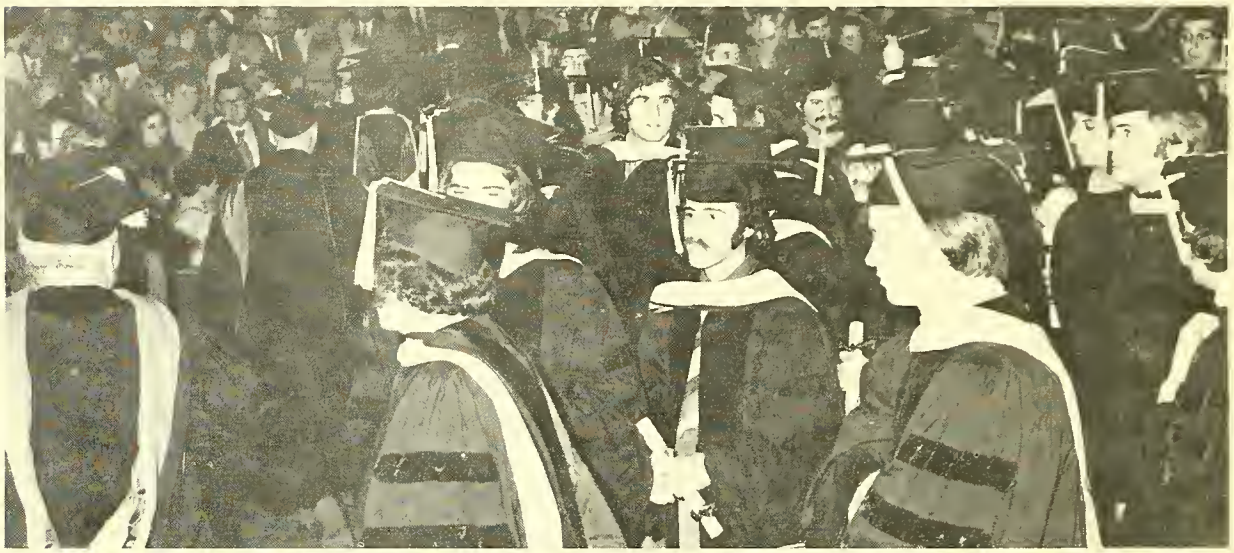
1. *Joint Funding Approach.* MCO and RMTI agreed to submit a joint funding proposal for the mutual benefit of both institutions.
2. *Optometric Screening Program.* MCO will establish a comprehensive screening program at RMTI. The participants will be limited to RMTI students.
3. *Tutoring, Counselling for MCO Students.* It was found to be necessary for MCO to explore the development of a formal program with RMTI and MCO's minority students so that these students can receive counselling and academic tutoring prior to entering MCO and during their stay there.
4. *Utilization of MCO Facilities.* It is desirous of RMTI to permit their students to be exposed to MCO's laboratory facilities for educational purposes.
5. *MCO Professional Resources.* MCO will identify appropriate minority students and faculty that can be utilized on the approval of RMTI. These MCO faculty and students will also serve as a source of providing health education.
6. *Mechanism for Communication.* Messrs. Jefferson, Vice President, and Parker, Student, will serve as MCO liaison. Messrs. Patrick Coggins and Vernon Souza as RMTI liaison. This is essential in order to sanction this initial effort.
7. RMTI requested MCO to sponsor a reception at MCO so that the students, faculty and staff of both institutions can meet informally.

These topics as drawn up by Mr. Octavius A. Rowe, Executive Administrator of RMTI, should prove to be quite helpful in establishing a formal relationship between MCO and RMTI, and in so doing, more students will become aware of optometry and what it is all about. It is also hoped that as a result of these efforts, the Black and Spanish speaking communities will indeed learn more about vision care and what impact it has on their health and daily lives.

Every city does not have a unique institution such as RMTI, or a dynamic and productive person, such as Mr. Rowe, to expend his energies and time in getting a similar program started. However, where there is an institution such as RMTI, its potential to recruit students for optometry should be explored. Thus, the time spent by students of optometry and the various optometric organizations can greatly be facilitated.

It is through the concerted efforts of minority students of all the health professions that the ever present problem of a severe shortage of minorities in medicine optometry, and dentistry can be alleviated to a great extent. RMTI has taken a giant step in this direction and this institution's relationship with not only MCO, but also with the various medical, dental, and health professional schools in the Greater Boston area could very easily serve as a model to those who wish to take a similar approach to the problem of minority recruitment.

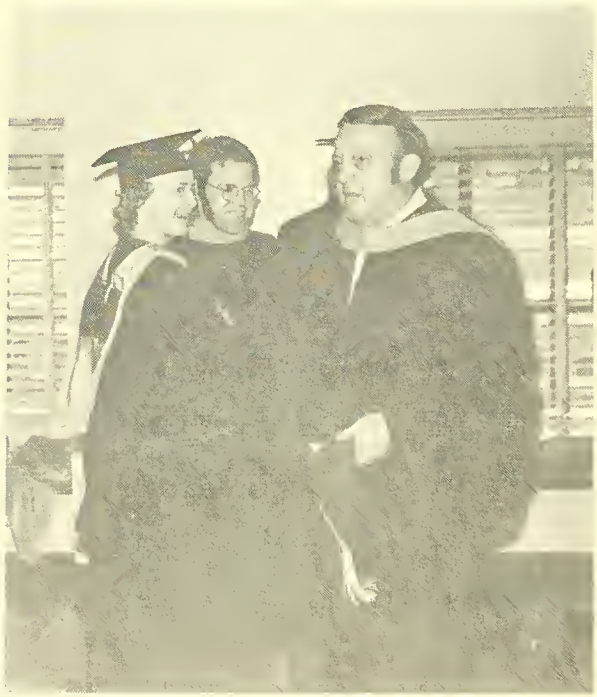
MCO GRADUATES 57 O.D.'S



MCO presented Doctor of Optometry degrees to 57 graduates, in exercises March 31 at New England Life Hall in Boston.

More than 700 parents and guests were on hand for the ceremonies, which featured an address by Brig. Gen. Manley G. Morrison, Chief of the Army Medical Service Corps.

Degrees were conferred by MCO President William R. Baldwin, assisted by Richard W. Baker, Chairman of the MCO Board of Trustees.



Honrary degrees were conferred by Joseph Jefferson, Vice-President of the college.

Gen. Morrison was among three outstanding leaders in health care who received honorary degrees from the college. In accepting the honor, Dr. Morrison praised work being done by optometrists in the military and said that there was ample opportunity for young optometrists just coming out of college.

An honorary Doctor of Humane Letters degree was conferred on Dr. Frances L. Ilg, retired Director of the Gesell Institute of Child Development. Dr. Ilg is a noted pediatrician and author. In many of her publications, she underscored the importance of vision in child development. She also recognized the role of optometry in eye care and had three noted optometrists in the Gesell Institute eye department.

In accepting her degree, Dr. Ilg, suggested areas of research in which she felt optometry could make new contributions.

Dr. Marshall V. Mark, a member of the class of '42, received an honorary of Doctor of Ocular Science degree. Earlier, he was the recipient of the 1973 Namias Award for excellence in teaching.

Dr. Mark is an Associate Professor at MCO, besides being widely known as a research scientist and author. Dr. Mark has published more than 100 papers.

Dean Hyman R. Kamens (class of '47) delivered the welcoming address. Assisting Vice-

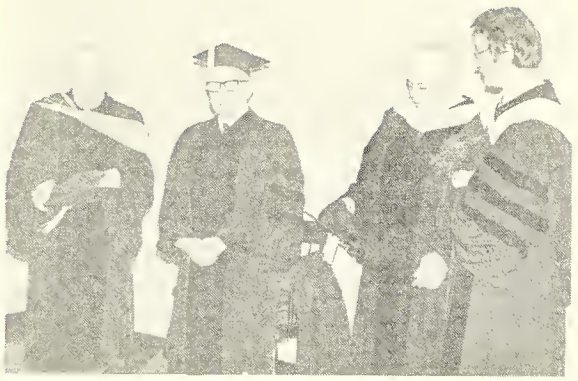
President Jefferson in conferring the honorary degrees were Drs. Ira Schwartz and John H. Carter.

The valedictory address was given by Kenneth J. Ciuffreda. This was the 79th annual graduation exercise held by MCO.

A list of 1973 graduates follows:

Jeffrey A. Adler, O.D.
Francis J. Aprea, O.D.
C. Roger Armstrong, O.D.
Stephen H. Ashinoff, O.D.
Jerry L. Baker, O.D.
William P. Beeaker, O.D.
Myron P. Berlatt, O.D.
Ethan Marc Bialostozky, O.D.
Jonathan Roy Birnbaum, O.D.
Edward J. Burns, Jr., O.D.
Wilfred Irving Butterfield, III, O.D.
Kenneth J. Ciuffreda, O.D.
Alan Ben Cooperman, O.D.

William E. Dolan, O.D.
Michael K. Edelstein, O.D.
Chester Scott Fichandler, O.D.
James Howard Freedman, O.D.
Arthur Jay Friedman, O.D.
Mark Emil Goldberg, O.D.
Joel David Goodman, O.D.
Barry Michael Gootson, O.D.
Howard Steven Grad, O.D.
Richard Alan Grossman, O.D.
Rodney K. Gutner, O.D.
Donald M. Harraghy, O.D.
Stephen Hecht, O.D.
Raymond Harris Helfand, O.D.
John P. Herman, O.D.
James Kelly Hester, O.D.
Donald S. Johnston, O.D.
David Ira Kahan, O.D.
Charles Ira Mandel, O.D.
John J. Maurillo, O.D.
Robert W. McQueeney, O.D.
Thomas W. Meaker, O.D.



Allen R. Neuhaus, O.D.
James R. Pearson, O.D.
Joseph A. Presti, O.D.
Jeffrey P. Rose, O.D.
Martin L. Sabesan, O.D.
David Schwartz, O.D.
Gerhard Sefranek, O.D.
Paul E. Seidel, O.D.
Gerald Jules Selvin, O.D.
Mark Gladstone Shafiroff, O.D.
Joseph Louis Shapiro, O.D.
Kenneth Robert Shepard, O.D.
Albert Lovering Sherburne, O.D.
Herbert Morton Shuer, O.D.
Terry Wayne Smith, O.D.
Richard Leon Stein, O.D.
William H. Vaughan, O.D.
David A. Vito, O.D.
Frederick J. Wagner, Jr., O.D.
Larry B. Wallace, O.D.
Michael C. Wellington, O.D.

CITATIONS PRESENTED AT GRADUATION EXERCISES

CITATION
FRANCES L. ILG M.D.

Dr. Ilg, was born and received her primary education in Oak Park, Illinois. Frances Ilg obtained her Bachelor of Arts degree from Wellesley College in 1925 and her Doctorate of Medicine from Cornell Medical School in 1929, with an internship at Saint Mary's Hospital for Children in New York City. From 1930 to 1936, Dr. Ilg worked at Bellevue Hospital in New York City, the New England Hospital for Women and Children in Boston and the Clinic of Child Development at Yale.

In 1936, Dr. Ilg was functioning as a Child Health Worker in Stockholm when she struck an early blow as a women's libber by adopting her daughter Tordis Kristen, who is now happily married and has made a Grandmother of Dr. Ilg.

From 1937 to 1950, Frances Ilg was assistant professor of Child Development at Yale. In 1950, The Gesell Institute of Child Development was formed under tenuous circumstances. Its continual rise in international prestige was due in great part to Dr. Ilg who functioned as its director from its inception until her retirement in 1970.

Starting with their publication of *Feeding Behavior of Infants* in 1937, that famous team of Gesell & Ilg published their world renowned trilogy *Infant and Child in the Culture of Today, The Child From Five to Ten* and *Youth: The Years from Ten to Sixteen.* There followed another equally famous team of Ilg and Ames which has produced three definitive works, notably, *School Readiness,* which is having a great impact on student entrance and placement within elementary school systems.

Prior to Gesell and Ilg, the accepted theory of development was that the child developed predominant on the basis of what was done to him. This has changed because Frances Ilg recognized, investigated and expounded on the biological timetable that controls many of our functions. Her ability in this field is unmatched.

In retirement, Frances Ilg is busier than ever, writing about and analyzing the world of children and their development.

The Members of the Board of Trustees of the Massachusetts College of Optometry salute you Dr. Frances L. Ilg, an eminent Pediatrician Scientist, Educator and a woman of warmth, humor and esteem and this day confer upon you the Honorary Degree of Doctor of Humane Letters. With this high honor go their sincere congratulations and best wishes for many more years of productivity.

CITATION
DOCTOR MARSHALL VICTOR MARK

Doctor Mark, a native of Massachusetts and an alumnus of this institution, received a certificate of optometry in

1942 and shortly thereafter accepted a commission in the United States Army. Following his discharge in 1946, he undertook postgraduate study at the Columbia University College of Optometry. And, subsequent study at this institution led to his receipt of the Doctor of Optometry degree.

Dr. Mark first engaged in private practice in 1951. Additionally, he served as Staff optometrist at the Massachusetts Eye and Ear Infirmary from 1953 through 1963, as Chief of the Orthoptics Clinic of the Boston Dispensary of the New England Medical Center from 1958 through 1964, and as a Staff Member of the Department of Ophthalmology of the Boston University Hospital from 1953 to present. His academic affiliations include faculty status both with the Boston University School of Medicine's Department of Opthalmology and with the Massachusetts College of Optometry. He has produced two patents, authored somewhat over one hundred papers and served on committees and in official capacities in a number of professional and scientific organizations in which he has held fellowship or membership. He is an outstanding teacher and the 1973 recipient of the MCO Namias Award for excellence in teaching. This award is based upon student selection.

With the Board of Trustees who have elected to grant Dr. Mark the honorary degree, Doctor of Ocular Science, I wish to extend my own expression of appreciation and congratulations. Dr. Mark's career has been distinguished by his qualities as an outstanding clinician, a scholar, a dedicated teacher, and always a gentleman.

CITATION
MANLEY G. MORRISON

Brigadier General Manley G. Morrison, Chief, United States Army Medical Service Corps was born and received his early schooling in Weston, West Va. After earning a Bachelor of Science degree at the University of Maryland, he went on to earn a Master of Arts degree in Public Administration at the American University. Enlisting in the Army in 1942, he quickly rose in rank as medical administrator to positions of increasing responsibility. A career officer, General Morrison's leadership qualities and technical competence were early recognized and brought him to a leadership role in the newly formed Medical Service Corps. After graduating from the Army War College in 1960, he rose in rank to Colonel and in 1969 was appointed as Chief, Medical Service Corps. with the rank of Brigadier General.

General Morrison's accomplishments throughout his career of service dedicated to health care needs of military personnel have earned him many honors, both military and civilian. However impressive, a mere recital of his military decorations and citations is insufficient to characterize the man inside the uniform. The Medical Service Chief requires a unique combination of human qualities necessary to guide man. Besides the character, self-discipline and leadership qualities nece4ssary to guide the direction and literally the careers and lives of thousands of men, an expertise and breadth of knowledge of the complexities of the various health care specialties, such as optometry, medical engineering, pharmacy and clinical laboratory procedures — among others — is also required. More than this and, perhaps, most important, the Medical Service Corps. Chief must possess a social consciousness and a sense of compassion that are shared by all health practitioners. Military men in the medical service must often walk a thin line between the necessary military discipline and humanitarian instincts for the sick and infirm. These rare traits of character should be given the fullest recognition when found. These qualities are the mark of General Manley G. Morrison whom we honor today. It is with great pride that, we, the Massachusetts College of Optometry, confer on him the honorary degree of Doctor of Humane Letters.

ANNUAL ALUMNI—SENIOR CLASS RECEPTION

The annual reception tendered to the Senior Class at MCO by the Alumni Association was held at the Play Boy Club in Boston on the night of February 2nd, 1973. A record turnout of the entire class was present, the only exception being one member who was ill at the time. The fifty-five members present enjoyed a convivial evening with attending members of the Alumni Association headed by Dr. Glen Gulezian, President of the Association.

A feature of the evening was the combining of the program with the actual business meeting of the Association during which the annual election of officers of the Association for the next term of two years was held.

The election resulted in the unanimous approval of the slate presented by the Nominating Committee at the previous Executive Board Meeting. Officers of the Association for the term of 1973 and 1974 will be:

President: Dr. Paul Montminy '65
Vice-President: Dr. Henry Boroyan '69
Executive-Sec'y: Dr. Morris Berman '30
Directors: Dr. John Callinan '63
(1973-76) Dr. Roger McCarthy '61

HARVARD CLUB AWARDS BANQUET GALA SUCCESS

The Awards Banquet was held in the Harvard Hall of the Harvard Club. A record crowd of two hundred and sixty-five people was in attendance including graduates, their families and friends, faculty, trustees, administrators, alumni, and representatives of many segments of organized Optometry.

Mr. Joseph Jefferson, Vice President, served as General Chairman and Host of the Evening. He introduced the double-tiered Head Table group as well as the other honored guests at the two main tables.

The group was welcomed by Dr. William R. Baldwin who congratulated the new graduates. Dr. William Baldwin and Dr. Richard Baker, Chairman of the Board of Trustees, then made a surprise presentation of the P.H.T. (Put Husband Through) degree to the wives of the new graduates.

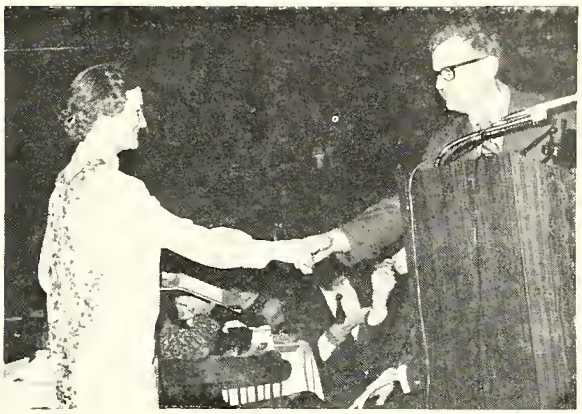
The presentation of the awards was supervised by Dr. Foster Namias Chairman of the Awards Committee, and Dr. John Carter, Academic Dean.

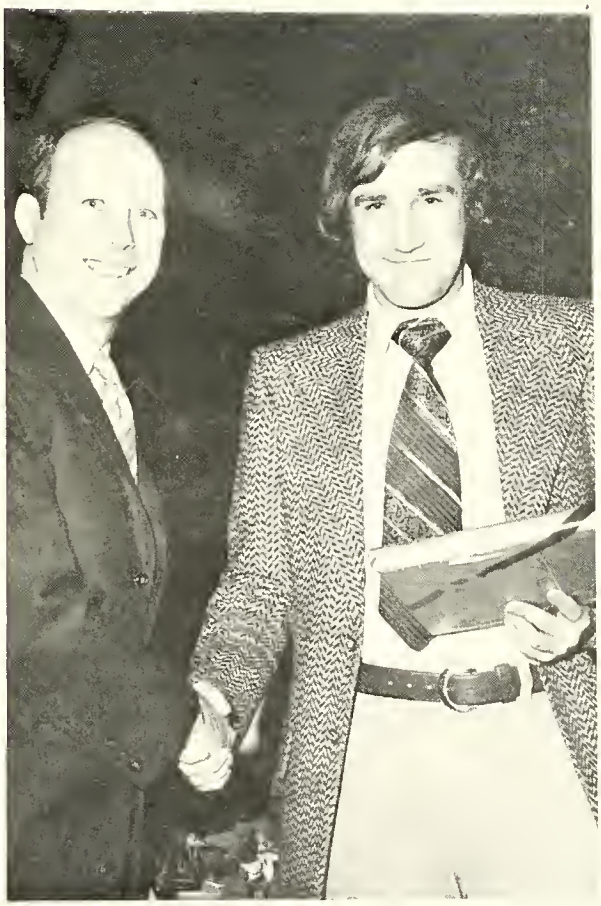
Kenneth J. Ciuffreda, valedictorian of the 1973 graduating class, received three top honors. He was the recipient of the Valedictory Award, the Dr. Ralph H. Green Gold Medal Award and the Beta Sigma Kappa Silver Medal Award. Dr. Ralph H. Green, Dean Emeritus, presented the Dr. Ralph H. Green Gold Medal Award.

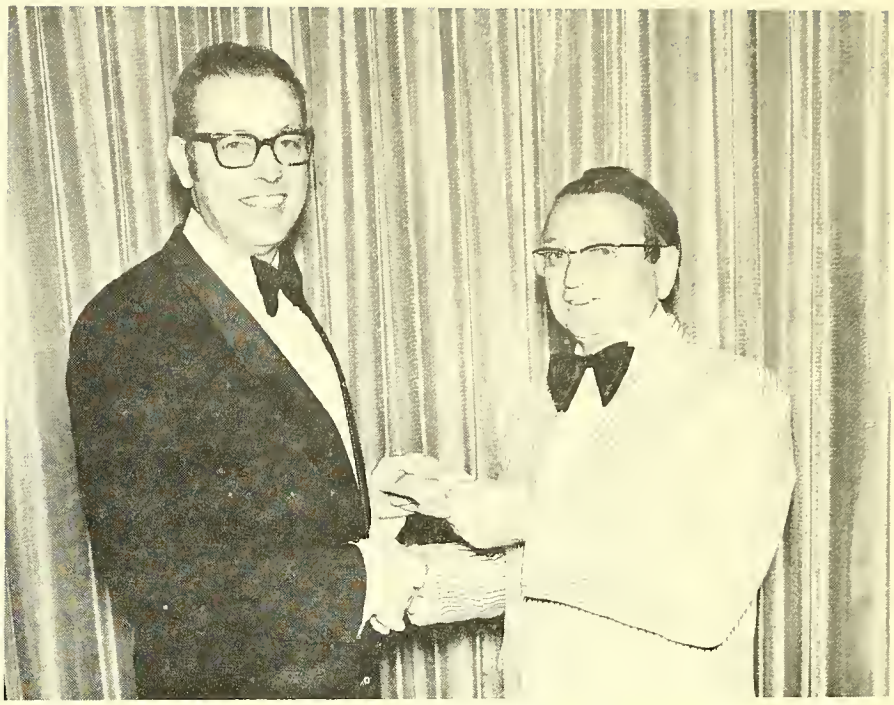
Dr. Charles Mullen, Director, General Clinic, presented the Clinic Award to John Herman.

The Daniel Kuperstein Memorial Award was presented to Michael K. Edelstein. The Frederick E. Farnum Alumni Award was presented by Dr. Paul Montminy, Alumni President to Chester S. Fichandler and John P. Herman. Dr. Montminy presented the Alumni Association Award to David A. Vito. Alumni Certificates were then issued by Dr. Montminy to the new graduates.

Dr. John Carter then presented the Dr. Edward Joseph Troendle, Jr. Award to Mrs. Eleanor Warner, Librarian on behalf of the Class of 1973.







A— Dr. William Baldwin, President of the College receiving check for $500 from Connecticut Society for Student Aid at the NECO Congress. Presented by Dr. Costos Poulos '43 President of Connecticut Society of Optometry.

B— Annual Alumni — Senior Reception at the Playboy Club

C— Parents at MCO Graduation Exercises

Vision Care in State-Supported Institutions for the Emotionally Disturbed and Mentally Retarded

By Louis A. Frank First Year Student

Personal experiences have on occasion taken me to several state supported mental institutions where I was appalled and sickened by the sad state of the patients. While a general outlook on patient status and facilities at institutions for emotionally ill and mentally retarded would require volumes, I decided to find out if we, in the field of vision care, are as guilty of neglect towards these unfortunate individuals as are many other professions and the public in general. It was my intent to find out what role optometry specifically plays in providing vision care to these types of institutions. This project began by the selection of a sample of 100 state-supported institutions for emotionally disturbed and mentally retarded throughout the United States. I prepared a questionnaire that would furnish me with an indication of the procedures followed and services available to patients in need of vision care within these institutions. A letter was sent to each of the fifty optometric associations asking for any available information on methods of visual examination and techniques used with mentally retarded patients. I then sent thirty letters to various government agencies and private vision oriented organizations to secure further information. The response was in general very good. This report describes the responses to my questionnaire and letters, in addition to certain pieces of information I researched from the library of the American Optometric Association.

On a nationwide basis, the overall average population of the state-supported institutions for the emotionally disturbed and mentally retarded in the United States is approximately 1,095. This average population is comprised of 626 males and 469 female patients. There seems to be a general trend towards improving facilities used for the mentally retarded while the inverse is true for those facilities limited to the emotionally disturbed. The amount of fund allocated for care of the mentally retarded far exceeds that of the emotionally disturbed. In many cases, there are limited recreational and entertainment facilities; however, there is normally a television set for each ward. In some cases, due to a patient's attitude or condition, television becomes their entire world. Upon visiting a few of these institutions, an observer notes patients viewing television an average of seven hours daily. Due to crowded conditions, some patients spend this 7 hour period viewing the television at a distance of two feet and others view the screen as far as fifty feet away, constantly straining to see. These viewing periods are interrupted only for meals. The lighting is often very dim and the patients who do read often do so under adverse conditions. There are, however, libraries furnished in many hospitals so that places with adequate lighting and materials are available to patients. Unfortunately, in many cases these reading facilities are located great distances from the various wards.

Unlike normal, healthy people, it is usually not possible to ask patients in mental institutions if they are having any visual problems. Not only must special techniques be employed but also, vision practitioners with exceptional insight and patience with people are required. So where do the various eye care fields come into play in the care of mentally retarded and emotionally disturbed people? Most state-supported institutions screened for this report have one vision care practitioner available either in residence and paid by the respective state government or found in the near-by community. There are isolated cases where patients are

taken in buses to visual screening projects or to community clinics for eye care. The number of ophthalmologists involved with mental institutions far outnumber the number of optometrists according to questionnaire response

Besides considering who should be providing the vision care, the nature of the examination should be considered. An attempt was made to determine what cues or signals indicate a need for vision care in a typical institution. The questionnaire answers indicated such vague generalities such as: "Eyes are examined when needed." or "When patient complains, his vision is checked." It is remarkable how many of these patients are unable to express themselves "in any way" and we can only infer from this fact that their vision is taken for granted. In any institutional situation, there is a tendency on the part of staff members to evaluate certain matters in terms of mass numbers. Obviously extreme care and attention is vital in areas involving communicable diseases and danger to many patients. However, in the case of visual disorders, fellow patients are not affected by one another and, therefore, concern is only superficial. Having spoken personally with former patients in institutions for the emotionally disturbed, I have been informed that it is generally true — if patients do not verbally express a complaint or ask for glasses, their visual capacities are not questioned. It is indeed sad commentary that those unfortunate individuals plagued by emotional disturbances continue to be neglected and ignored. And so, in the case of the vast majority of those with emotional and mental illnesses and particularly those over age 40, in addition to the dim-ly lit quarters, crowded conditions, starchy unnourishing food, shabby clothes, peeling paint, cruelty of family, that are often found, one must add to the list a significant portion of patients with poor or inadequate vision care. In researching this topic, I worried that so much information must have already been gathered that this report would be redundant. However, it appears that the vast majority of research related to mental illness has been concentrated into analysis of programs available to the mentally retarded, that group of usually young people that are granted by society the privileged title of those with "hope." I encountered a degree of difficulty gathering statistics about the vision care available to emotionally disturbed persons because these institutions are centers of constant suspicion and investigation. There was resistence to inquiry on my part. It also appears that optometry plays a relatively small part in the distribution of vision services to the emotionally disturbed. It seems absurd that every instituion of this type does not give each new patient an intenstive entrance eye examination. Unfortunately, many of the emotionally disturbed, once admitted, remain in the institution forever. It would certainly be in the best interest of the patient to have his vision completely checked upon admittance to the institution. This does not mean merely reading the Snellen Chart, but a comprehensive examination. It should be pointed out also that once a need for glasses is established, in most cases the patients must themselves provide the cost of the glasses. Considering the fact that an alarming number of the emotionally disturbed are abandoned, where does the money for glasses come from? The answer is realistic and simple. The money never comes and many patients learn to live without proper vision. There are, fortunately, several private philanthropic organizations throughout the United States which pay for glasses needed by emotionally disturbed patients. In summarizing the vision picture of these institutions, it would appear that the vision professions do not play a large enough role in caring for the emotionally disturbed. This most probably is due to the same situation which plagues all forms of care for these individuals, i.e., lack of funds, low confidence in recovery potential and misunderstanding.

The vision care situation for the mentally retarded is brighter. The facilities provided for medical care of mentally retarded patients are often modern, clean and extensive. There is an abundance of organizations and governmental agencies concerned with the welfare of these patients. It is in researching this area, where optometry seemed to stand out as a shining star. It is a startling fact that mental retardation is on occasion diagnosed or exaggerated when, in fact, the problems of a child may be due to nothing more than a very large degree of myopia, for instance. In discussing the examination of children considered "slow" with an optometrist in the Albany area, I was told of a case where a "mentally retarded" child was brought in for an eye examination. It was difficult to elicit adequate responses from this child. Then, by chance, the optometrist placed some high minus

lenses in front of the patient wearing a trial frame. The child started yelling and grabbed the frame with his hands when the optometrist started to remove it. The child would not let go or take the frame off. After having discovered the high myopia and treating the patient accordingly, the child began to progress and to catch up with the normal children. This particular incident occurred by chance, but required a practitioner with a lot of patience and perseverance. Several of my letters to Optometric Associations were channeled to optometrists who are specifically dedicated to working with problem situations: low vision, mental retardation, etc. I found that there are, indeed, a number of very interested and dedicated optometrists in the United States — each with their own impressions and techniques concerning the mentally retarded.

It would appear that as more sympathy and hope are expressed for the mentally retarded, vision care will follow the trend which is more interest and initiative in their care. It is a credit to vision care fields and optometry specifically that there are those dedicated so strongly to the direction of others and care of the mentally retarded. This does not imply that there are no problems of ignorance or neglect of mental retardation by the vision care fields. There is much room for improvement in this area also but on a comparative basis vision care for the mentally retarded far surpasses that which is available to the emotionally disturbed.

April, 1973

SAVE YOUR VISION WEEK PROGRAM PRESENTED BY MCO CHAPTER OF AMERICAN OPTOMETRIC STUDENT ASSOCIATION

The first program sponsored by MCO Chapter of AOSA was held during the week of March 4th — 10th, 1973. Planned meticulously by Ron Ferrucci '74, and co-ordinated with the help of Dr. William Baldwin, President of M.C.O., Mr. Joseph Jefferson, Vice-President of M.C.O., Dr. William Schuller, Director of Vision Screening at M.C.O., and Dr. Robert Golden '62, Assistant Clinical Professor, the schedule included visits to various high schools in Boston and vicinity of members of the M.C.O. student body who explained the role of Optometry among the health professions providing visual care. In the succeeding days of the SAVE YOUR VISION WEEK there were exhibits and demonstrations of visual phenomena at the Dudley Grammar School in Roxbury, lectures and panel discussion by professionals in major visual research projects, a sample Visual Screening Program conducted under the supervision of M.C.O. student body and faculty members for a full eight hours for students from Grade one through High School in the Roxbury area.

The enthusiastic MCO student involvement in the SAVE YOUR VISION WEEK program augers well for the future of Optometry. All involved are to be congratulated on their successful effort.

Continuing Education

An opportunity for all those professional personnel interested in a program leading to the Doctor of Optometry degree (O.D.) is again available at the Massachusetts College of Optometry.

The program will be 48 weeks in length began March 14, 1973. Classes will be held every Wednesday from 9 A.M. to 4 P.M. with the exception of holidays and a summer break will be arranged. The tuition has been set at $1,200 for the full course.

Listed below are the next two sections of the Continuing Education Program.

Those interested in further information should contact Dr. H. Kamens, Dean of Administration as soon as possible.

Motility Evaluation

The course will be given on six (6) Wednesdays. The exact dates are given along with the subject matter to be discussed. Tuition and fees for Course No. 3: $165.

Week No. 1	(18)	3 hours
15 August		2 hours
Week No. 2	(19)	3 hours
22 August		
		2 hours
Week No. 3	(20)	3 hours
29 August		
		2 hours
Week No. 4	(21)	3 hours
5 September		2 hours
Week No. 5	(22)	3 hours
12 September		2 hours
Week No. 6	(23)	2 hours
19 September		2 hours

Binocular Vision
The Extraocular Muscles and Their Functions

a) Nystagmus
b) Vertical Imbalance
Binocular Tests

Testing Methodology in General Squint Diagnosis
Evaluation of Status of Binocularity

Concomitant Squint (Diagnosis)
Noncomitant Squint (Diagnosis)

Sensory Adaptations in Squint
Other Motor Anomalies Affecting the Visual System

Strabismus and Amblyopia (Therapy)
Strabismus and Amblyopia (cont'd.)

Ocular and Visual Development

The course will be given on seven (7) Wednesdays. The exact dates are given along with the subject matter to be discussed. Tuition and fees for Course No. 2: $190.

Week No. 1	(11)	3 hours
23 May		2 hours
Week No. 2	(12)	3 hours
30 May		2 hours
Week No. 3	(13)	3 hours
6 June		2 hours
Week No. 4	(14)	3 hours
13 June		2 hours
Week No. 5	(15)	3 hours
20 June		2 hours

Week No. 6	(16)	3 hours
27 June		
		2 hours
Week No. 7	(17)	3 hours
11 July		
		2 hours

Ocular Genetics; Adaptive Processes
Ocular Embryology

Perceptual and Learning Factors in Vision
Congenital Developmental Anomalies of the Eye and Its Adnexa

Examination of the 3-year Old
Inherited Familial Ocular Disease

Examination of the 3-year Old (cont'd.)
Inherited Familial Ocular Disease (cont'd.)

Psychological Factors in Vision Care
Genetic Counseling

Identification of Visually Related Learning Problems
Identification of Visually Related Learning Problems (cont'd.)

Management of Visually Related Learning Problems
Management of Visually Related Learning Problems (cont'd.)

Dr. Lambert Given Honor by Jaycees

Richmond Times (Va.) - Dispatch 1/17/73

Dr. Benjamin Lambert III, an optometrist, received the Richmond Jaycees' "Outstanding Young Man 1972" award yesterday during a meeting of the Richmond Rotary Club at Hotel John Marshall.

M.C.O. OPTOMETRIC ASSISTANTS PROGRAM CONTINUED

A continuing program for Optometric Assistants is scheduled for the summer of 1973, depending on the existing demand.

The course of study will be divided into two sections; Ophthalmic Optics and Optometric Procedure. Emphasis will be placed on such areas as frame styling and selection, fitting and dispensing of prescription spectacles, and procedures used in performing a visual analysis as done in an optometric office.

Anyone interested or if any alumni interested in enrolling their optometric assistant for this course of study may obtain complete details of the program by writing to:

Division of Optometric Assistants
Attention: Dr. Mary Scott
Massachusetts College of Optometry
424 Beacon Street
Boston, MA 02115

M.C.O.

Class of 1923

See anyone you know?

This was taken in 1923.

Top Row (Left to Right)
Dr. Gerald Goodrich (Deceased), Dr. Harold Elliot, Dr. Stanley Hawk, Dr. George C. Harrington, Dr. H.C. Brown, Dr. Raymond H. Richards (Deceased)

Second Row:

Dr. Louis Carney (Deceased), Dr. Thomas Seaver, Dr. Joseph Griswold, Dr. Joseph Craven (Deceased), next two individuals unidentified.

Bottom Row:

Dr. Green, Dr. H. Melba Flockton Graham, Dr. Walter N. Howe, Dr. W. Fuller (Deceased), Dr. Jacob Harris.

Active Alumni Membership For 1972

This list of paid-up members for 1972 is in addition to the list of names published in the Winter 1973 Alumni Journal. It includes the names of some who were inadvertently omitted due to printer's error and those who have sent in their dues after the cut-off publishing date of December 20th, 1972

Benjamin T. Hamilton '47
John DiNapoli '37
Theodore C. Edmonds '66
Nathan Aronson '41
Henry A. Bershad '48
Ralph Mann '50
Everett Sawyer '52
Joseph E. Cauley '50
Victor Finnemore '69
Paul E. Grattan '63
Lynde H. Kimball '57
Eugene J. Longo '49
William Myers '52
James Pickering '37
Bernard Rosen '61
Emerson Smith '50
Benjamin Snyder '32
John J. Brack '48
Solomon Lipsky '34
Gerald Melore '68
Jon Volovick '69
Thomas Baker '60
Stanley Gilman '39
James Michaud '64
Maurice Morin '43
Amelia Rodd '39
Lester Thomas '34
Lewis Beckwith '41
Alfred Blanchard '68
Charles Blom '33
Anna Buonfiglio '27
Gerald Garand '57
Albert King '49
Brian Roy '71
Gordon Rand '38
Arthur W. Baker '67
Edmund W. Cowie, Jr. '60
Robert Honnors '63
Gerald Kass '62
Peter Kumpitch '70
Charles Leighton '57
Joel Marcus '69
Barry Meyer '66
Daniel Murray '61
Holmes Obenauer '37
Thomas Piecewicz '69
Samuel Goodfader '41
Edward Holman '49
Martin Kaplan '66
Marvin Finkelstein '59
Gerald Harris '65
Lawrence Kline '67
Joseph Mittleman '42
Julius Shuldiner '53
William Ling '67
Dearborn L. Shaw '33
Paul M. Stein '57
Roland DeCesare '44
Alfred Rappaport '50
Michael Zucker '68
Joseph Clark '52
John Meagher '49
Richard Tacelli '52
Richard Baker '32
Richard Glenn '61
Donald Griggs '49
Louis Wain '39
Mitchell Begdigian '49
Paul DeCesare '69
Harold Goren '48
George Leavitt, III '67
Mario Nigro '39
Lewis Palosky '69
Frederick Cohen '50
Philip Goldfarb '34
Dewey Clason '59
Herman Katims '58
Luther Bickmore '43

We regret to announce the death of our fellow members:

Dr. James Arsenault '27, Worcester, Massachusetts
Dr. Richard T. Fraher '27, Bridgeport, Connecticut
Dr. Samuel Gabe '28, Tenafly, New Jersey
Dr. John T. Bedell '33, Gloucester, Massachusetts
Dr. Samuel Silverman '65, Brooklyn, New York

News and Views From and About Alumni

? WHERE ARE THEY NOW ?

(This column is devoted to the effort of keeping our mailing lists up to date. Please notify Dr. Morris L. Berman, Sec'y, MCO Alumni Association, 424 Beacon St., Boston, MA 02115 if you have the present address of the alumni listed below.)

Dr. Gregory Eaton '69
Dr. Solomon Pasichow
Dr. Edward Morally '36
Dr. Lawrence Carmen '52
Dr. Anthony Uva '52
Dr. Robert Gold '67
Dr. Victor Finnemore '69
Dr. Paul Barthel '50
Dr. Harrison Smiley '68
Dr. Robert Rodman '42
Dr. Howard Klapper '59
Dr. Joseph Strauss '60

February 20, 1973

Dear Dr. Berman:

I just received my Winter 1973 copy of the Alumni Journal and I would like to commend everyone connected with it. It is a beautiful job well done and I realize that most of the time the staff labors thinking that nobody out there really cares or appreciates what they do, so here are a few words of praise, well deserved.

I would also like to mention that this past winter I served on a committee of the Maryland Optometric Assn. to investigate how the average practitioner can help in the financial crisis that is now facing our optometric schools. I believe we were the first state association in the country to vote a voluntary increase of $10/year for each of the next five years in AOA dues so that at the end of that time $50 from each optometrist will go to Optometry Schools. With the Nixon Administration cutting down higher education appropriation, especially for our group, it is absolutely necessary for each alumnus to sponsor similar resolutions in their state association and then support it at the National Convention in San Francisco. It is the only way to protect the independence and viability of our optometric schools. Keep up the good work.

Sincerely yours,
E.R. Werthamer O.D.
Class of '50

WHO GETS IT?

Optometric items of historical value to museums and archives are now being marked with small stickers indicating to whom they should go upon their owner's death.

The AOA's Optometric Historical Society is furnishing the stickers to be affixed to books, instruments, correspondence files, diplomas, photographs, documents, patent papers and other materials to permit the owner to retain possession of the items during his lifetime yet assuring that they will later go to the recipient of his choice. This also provides a way to prevent loss of the material through careless discarding by someone not familiar with its historical value.

Stickers are available at $1 for six from the Optometric Historical Society, 7000 Chippewa St., St. Louis, Mo. 63119.

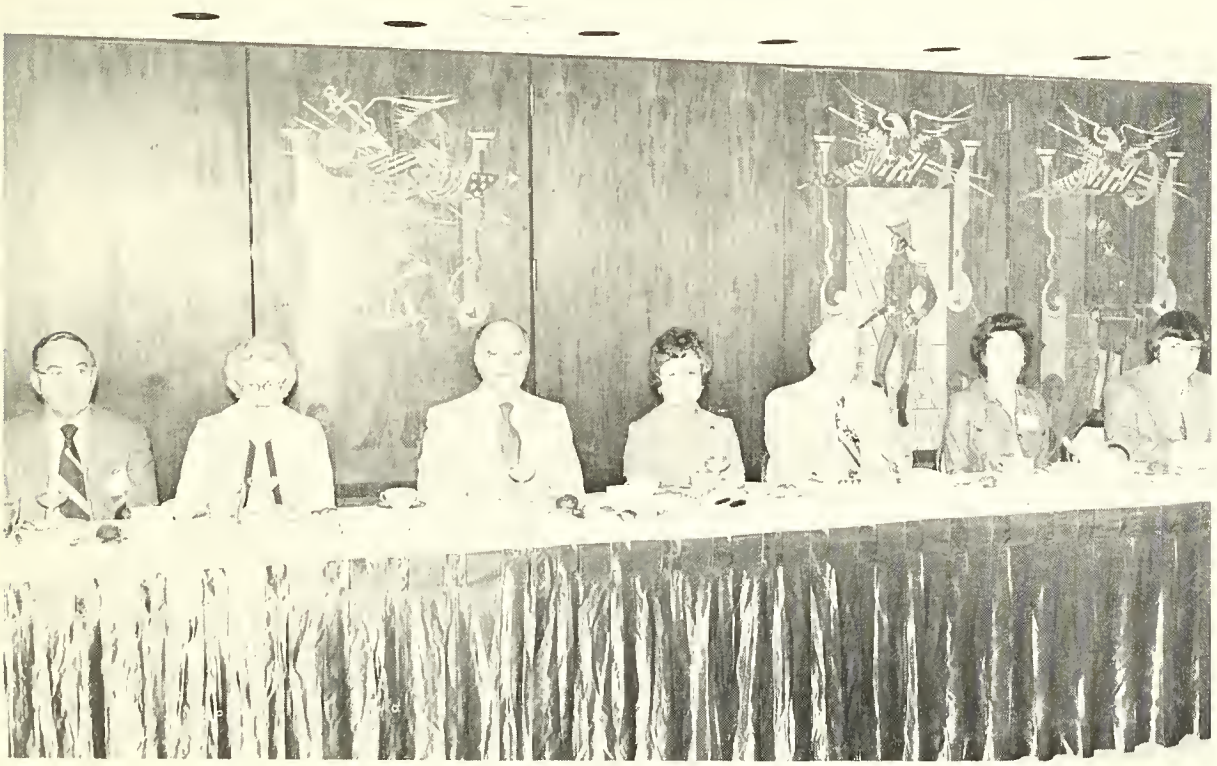
ANNUAL ALUMNI LUNCHEON AND INSTALLATION OF OFFICERS

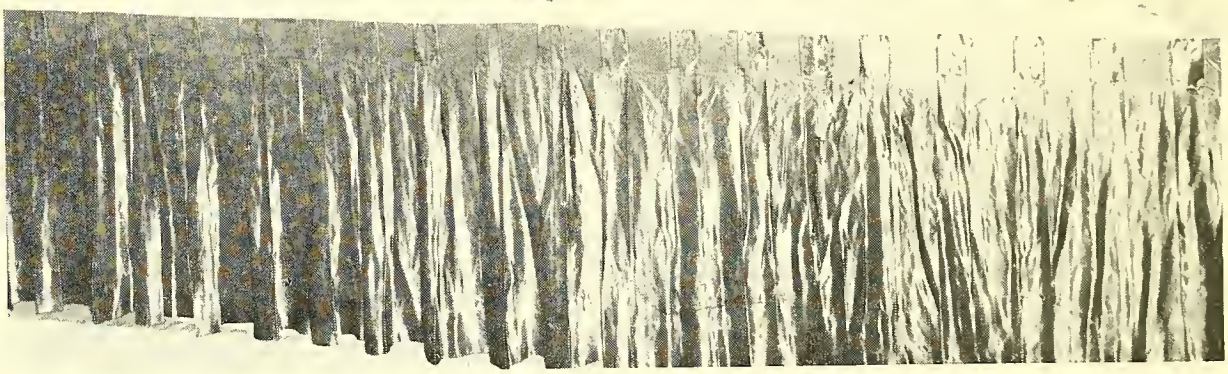
The Annual Luncheon of the Alumni Association held on the occasion of the New England Council of Optometrists Congress, March 18th 1973, was attended, once more, by the maximum number of members able to be seated in the largest available room at the Sheraton-Boston Hotel. The policy of strict advance reservations resulted in a meeting which followed the time and events schedule planned without the usual scramble for seats and congestion at the door which formerly delayed the start of the program.

The program began with a welcome by Dr. Glen Gulezian '65, retiring President of the Association, an invocation given by Dr. Richard Baker '32, Chairman of the Board of Trustees of the College, and greetings from Dr. John C. Maheu, President of the New England Congress of Optometrists. Dr. John C. Tumblin, President of the American Optometric Association, administered the oath of office to the incoming slate of officers of the Alumni Association after speaking briefly on the problems confronting Optometry today and outlining some of the steps being taken by our national organization in their resolution.

Dr. Paul Montminy, newly-installed President of the Alumni Association, welcomed the members and guests present with a short speech exhorting all members to contribute their share in time and money and ideas in maintaining the Association as a dynamic branch of the College. An interesting highlight of Dr. Montminy's address was the welcome to the Class of 1923, assembled by Dr. Walter N. Howe '23 in a fiftieth Class Reunion, and attended by Dr. Harold Elliot '23 and Mrs. Elliot, Dr. H. Melba Flockton Graham '23 and Mr. Graham, Dr. Joseph Griswold '23 and Mrs. Griswold and guest. (See original class picture '23 on page 22)

The Luncheon Program also featured awards of Plaques to Dr. G. Burt Holmes, Trustee, A.O.A., and to retiring President of the Alumni Association, Dr. Glen Gulezian. Dr. William Baldwin, President of MCO addressed the guests present with an up-to-date resume of College activities and projects for the future.





FACT SHEET

MCO Building Fund Campaign

On 10 August 1971, the College entered into an agreement to purchase the Beacon Street property where we are now housed. At that time, the City of Boston was in the process of taking our Newbury Street property and was to compensate us at $675,000.

The purchase price of the buildings was $1,200,000. We borrowed $200,000 against the Newbury Street property to make a down payment. The balance of $1,000,000 is to be paid at the rate of a minimum of $100,000 per year, with a baloon payment of the balance due on 10 August 1976.

In Phase I of the Building Fund Campaign, $372,000 was pledged by optometrists and by members of the New England Optical Wholesalers Association. Our projection of payment for the Beacon Street property is:

Total purchase price	$	$1,200,000
Paid at closing (8/10/71)	200,000	
Paid by 8/10/72	100,000	
Paid by 8/10/73	100,000	
To be paid at sale of Newbury Street property	260,000	
Balance in Building Fund Pledges	190,000	
		850,000
Balance to be Paid		$ 350,000

Two hundred and eighty-five optometrists contributed gifts and made pledges during Phase I of the campaign; 162 pledged $1,000; 45 pledged $2,500; 16 pledged $5,000; and 1 pledged $6,000. The balance pledged smaller amounts.

Our current goal is to raise $300,000 (or essentially the balance which we need (to pay off the building) from the approximately 1,000 alumni of the College who have not yet made a commitment of support. We believe this can be accomplished best by asking alumni to contact members to their class requesting their support to complete the acquisition of funds to completely finance the purchase of our new facilities.

If we can meet this schedule, we will not have to pay any interest. In fact, if we can pre-pay we will save 4% per year on the total purchase price. This will have the effect of making everyone's contribution go further and is an opportunity we should not fail to cash in on. We must raise all funds by 10 August 1976 to fully meet our goals and maximize this special opportunity for the College.

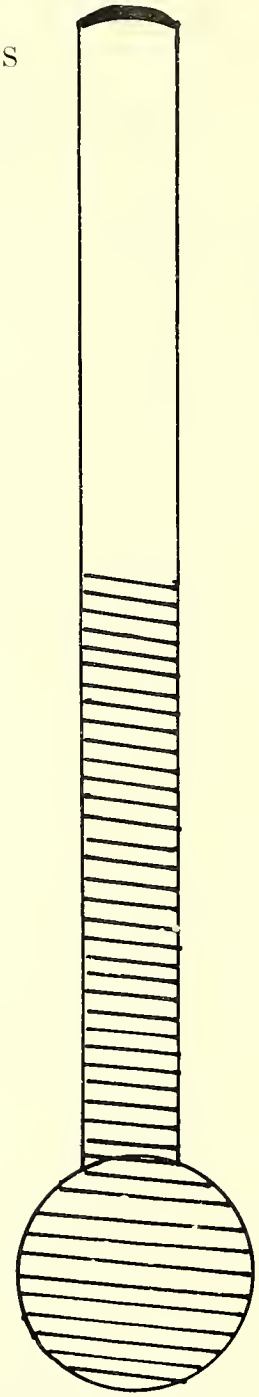
PHASE II BUILDING FUND APRIL — DECEMBER 1973

DEWEY CLASON — CO-CHAIRMEN — IRVING FRADKIN

— GOAL $625,000

PHASE II CLASS CAPTAINS

'18—'30 Morris Berman '30
'31 Mark Forgues '31
'32 John Asarkof
'33 Nathan Lager
'34 Adelbert Parrott
'36 Max Fishelson
'37 Richard Ferris
'38 Leonard Pacheco
Alfred Hanson
'39 Donald Feltus
'41 Nathan Aronson
'42 Robert Rodman
'43 Joseph Craven
'44 George Danielian
'45 A. DiMauro
'45 Edw. Goldenberg
'47 Morton Shaw
'48 Robert Bianchi
'49 Donald Nahigyan
'50 Jack Baboian
'52 William Myers
'53 Joseph Medeiros
'54 Morris Toll
'55 William Tolford
'56 Albert Roy
'57 Charles Connors
'58 Philip Hughes
'59 Forrest Seavey
'60 Joseph Comalli
'61 Joseph Donatelle
'62 Robert North
'63 Joseph D'Amico
'64 Carl Gustafson
'65 Glen Gulezian
'66 M. Garsten
'67 David Regan
'68 Les Brackley
'69 Henry Boroyan
'70 Pauline Beale



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PLEDGE YOUR FAIR SHARE WHEN YOUR TURN COMES. YOUR FUTURE AND THE FUTURE OF OPTOMETRIC EDUCATION DEPENDS ON *YOUR* PLEDGE.

A Closer Look at Diagnostic Drugs for Optometric Use

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Historically, optometry has been a drugless profession. The early state optometry laws, almost without exception, used the phrase, "any means except drugs to diagnose ocular abnormalities," in defining the tools an optometrist may use to practice his profession. These laws were passed between 1903 and 1924, and in most cases have remained unchanged with regard to drugs since those early years. The profession itself has changed considerably during this period. There also has been a considerable improvement in the types of ocular medications available. None of the drugs I shall be discussing were available fifty years ago, or for that matter, with the exception of phenylephrine, even twenty-five years ago. They all are less toxic, less irritating, and shorter acting than their predecessors.

Optometry school courses have changed with the times and now include courses in pharmacology and, even more important, now include clinical training in the use of these agents. Finally, technology has given us better and more sophisticated equipment in the lab and in the examining room, along with better trained optometrists, and more para-professional personnel. All of these factors have enabled the optometrist to spend less time in the lab and in information-gathering activities. They enable him instead to devote more time to thinking in terms of the patient's eye health, general health, and the visual demands of his patient's environment.

In order to perform a more complete general optometric exam, I do not feel that any of us would disagree that we could do an even better job with greater ease for some patients with the aid of diagnostic agents I shall now discuss. I plan to stress the disadvantages of these agents with references to the reported adverse literature. I also would like to give you my personal experiences as a clinician who has had considerable exposure to these diagnostic agents.

USE OF LOCAL ANESTHETICS

Why use local anesthetics?

The main reason for optometry to use local anesthetics is to better measure the intra-ocular pressure. Most of the presently available non-anesthetic tonometry devices are costly and give the patient discomfort as well as apprehension. It is well known that none of the above-mentioned devices are as accurate without anesthesia or as repeatable as the Goldmann-type tonometer. This tonometer is the standard against which all other tonometers are measured, and is the type used by most specialists who treat glaucoma. It is therefore obvious that if we also use it there is a smaller margin for error.

Local anesthetics of choice.

Benoxinate (Dorsacaine)

Proparacaine (Ophthaine, Ophthetic)

Disadvantages of local anesthetic use.

1. The blink reflex is inhibited and thus the patient is more likely to not blink a foreign body out of his eye.
2. The corneal epithelium is softened.
3. The corneal epithelial healing is retarded.
4. The possibility of local reaction.

Literature on adverse reactions to the above local anesthetics.

1. Benoxinate

   No reactions of any nature have been reported in any literature I have read.

My main textbook references will be: *Ocular Therapy* by Irving H. Leopold; *Ocular Pharmacology* by William H. Havener; and correspondence with Barnes-Hind, the manufacturers of Fluress. I have seen Benoxinate in combination with Fluorescein (Fluress) used in over ten thousand patients and have observed no ill effects

2. Proparacaine (Ophthaine, Ophthetic) Leopold makes no comment about local reaction to this medication. He does emphatically state that "there have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye." Havener says "Proparacaine has not been found to cause a significant incidence of allergy. The only patient I have ever recognized to be sensitive to proparacaine required repeated tonometry for chronic simple glaucoma. After several years she developed marked sensitivity to proparacaine." Correspondence with Squibb, the manufacturers of Ophthaine, led to a report in *The Eye, Ear, Nose and Throat Monthly* of June 1968. This report was by F. H. Theodore, M.D., on "Idiosyncratic Reactions of the Cornea from Proparacaine." In this report he cites six cases of what he terms acute reactions to propracaine. In four of these, the patient had either received several drops of the anesthetic over a short period of time or had many reported episodes of allergies to other eye medications. In examining the other two cases one cannot help but include the possibility that the patient got something in her anesthetized eye shortly after leaving the doctor's office. My personal experience in over ten thousand administrations of this medication has shown no evidence of any local reaction. There was one instance of a patient going out-of-doors shortly after instillation of the anesthetic. While outside he got a foreign body in his eye, rubbed his eye, and gave himself an abrasion.

Action and dose of the local anesthetic of choice.

1. Use only one drop properly instilled in each eye.
2. From one drop you will obtain anesthesia in ten to fifteen seconds. This anesthesia will last ten to fifteen minutes.
3. Proper instillation of any eye drop basically consists of placing the drop in the outer canthus of the eye (so as to avoid drainage by the puncta) and not touching the dropper tip to the lashes or any other unsterile surface.

USE OF MYDRIATIC AGENTS

Why use mydratics?

Most optometrists would agree upon the merits of routine use of local anesthetics. General agreement would not be as great when routine use of mydriatic agents is considered. There should be no disagreement, however, that some patients could be better examined with the aid of these mydriatics. Some of the more obvious reasons for dilation are as follows:

1. To better examine the fundus of the patient with small pupils. We have all had patients whose disc and/or macular area could not be viewed with normal ophthalmoscopy procedures.
2. To better evaulate lens changes and the general overall condition of the crystalline lens.
3. To better examine the fundus of youngsters who do not cooperate fully.
4. To better examine the periphery of the fundus. (For changes such as those seen in the retinitis pigmentosa, diabetic retinopathy, hypertensive retinopathy, active choroiditis, posterior uveitis, retinal detachment, and malignant melanoma.)
5. To offer an additional method of obtaining a good static retinoscopy on young children, retarded adults whose cooperation is minimal, small pupil patients, and non-English speaking patients who may have difficulties in understanding your instructions.

Types of mydriatic agents.

Sympathomimetics - or mimickers of the sympathic system. These agents act like adrenalin which is the main chemical conductor substance in the sympathetic system. They cause the classic "fight or flight" reaction which includes pupil dialtion. The ciliary body is thought not to have any sympathetic innervation (parasympathetic only) and therefore accommodation is not affected.

Parasympatholytics - or blockers of th parasympathetic system.

The parasympathetic system influences the eye by causing pupil constriction and increased accommodation. Blocking this system, as these drugs do, causes dilation and loss of accommodation.

Sympathomimetic mydriatics of choice.

Phenylephrine (Neo-synephrine 2-1/2% or 10%)

Hydroxyamphetamine (Paradrine 1%)

Disadvantages of sympathomimetics.

1. Increase in photophobia (due to dilated pupil).
2. Decrease in intra-ocular pressure.
3. Increase the chance of angle closure glaucoma *in susceptible patients with narrow angles.* Slightly less than 2% of our patients have narrow angles. The vast majority, ninety-eight per cent, have open angles. (1) Dilation *opens* the angle up even more in all patients except those with narrow angles. (2) One may perhaps wonder what the incidence of angle closure glaucoma would be if patients were routinely dilated. In chapter four, volume threee, of *Ocular Therapy,* edited by Irving Leopold, M.D., we are given the following information: "Abraham in 1955 surveyed the literature for reports of acute glaucoma produced after the use of mydriatics in patients previously free from clinical signs of glaucoma..... He calculated an incidence of one case of acute glaucoma for each 18,400 instances of application of anticholinergic eyedrops for refraction or other eye examination." In Abraham's data it was strikingly evident that age was an important factor in determining susceptibility to acute glaucoma. In nearly all instances of acute glaucoma the patients were over 30 years of age. Among patients younger than 30 years, Abraham found only four instances of this type of adverse effect in all the literature. Also, it must be emphasized that the above one case in 18,400 patients, was from a population group who were dilated without the aid of angle evaluation techiques.

Literature on adverse reactions to the above sympathomimetic mydriatics.

1. Phenylephrine
   Neither Leopold nor Havener make any significant remarks as to adverse reactions with this medication. One of its more obvious side effects theoretically would be increased blood pressure. Clincially, however, this was found not to be the case. (3) Neither the drug company nor the PDR report any adverse reactions to this medication.
2. Hydroxamphetamine
   I could find no reports of ill-effects from topical instillation of one drop of this medication.

Action and dose of sympathomimetic mydriatic of choice.

Use only one drop for pupil dilation. Dilation will occur within twenty minutes and last for three to five hours.

Parasympatholytic mydriatics of choice.

Tropicamide (Hydriacyl 1/2%, 1%).
Cyclopentalate (Cyclogel 1/2%, 1%, do not use 2%).

Disadvantages of parasympatholytics.

1. Increase in photophobia.
2. Loss of accommodation.
3. May slightly increase in intra-ocular pressure.
4. Increase the chance of angle closure glaucoma in narrow angle patients only. The xplanation is the same here as it was when sympathomimetic mydriatics were discussed. The nature of the angle closure glaucoma caused by parasympatholytics is thought to be slightly more dangerous than the angle closure glaucoma caused by sympathomimetics. The reason for this is that the sympathomimetic drug reaction is more easily reversed by pilocarpine.

Literature on adverse reactions to the above parasympatholytic mydriatics.

1. Tropicamide
   Neither Leopold nor Havener report any ill effects from this medication. Correspondence with the manufacturers, Alcon Labs, led to a single report of what may be termed an adverse reaction. This report was given by Dr. Joseph Wahl in the September, 1969, *Archives of Opthalmology.* It may be summarized simply by stating that the patient fainted after instillation of one drop of .5% tropicamide.
2. Cyclopentalate
   Havener, the PDR, and various other sources mention reports of adverse reactions to the 2% solution, or repeated doses of the 1% solution. These reactions generally consisted of transient personality changes and disorientation in young children.

Action and dose of parasympatholytic mydriatic of choice.

From the use of only one drop you will have a semi-dilated pupil as well as cycoplegia in twenty minutes. The tropicamide effect will last three to six hours, the cyclopentalate effect will last twelve to thirty-six hours.

Combined use of sympathomimetic and parasympatholytic mydriatic agents.

One drug from the sympathomimetic group may be combined with one drug from the parasympatholytic group. This combination will produce a greater dilation than any of these agents alone. This may best be understood by remembering how these drugs work. The former dilates by stimulating the iris dilator (radial muscle), the latter by paralyzing the iris constrictor (iris sphincter). Therefore, a greater dilation is obtained by the concomitant usage of these two drugs.

USE OF MIOTIC AGENTS

Why use miotic agents (i.e., pilocarpine)?

1. Routine use after dilation. This is definitely not recommended as a routine office procedure. The pilocarpine constriction and accompanying accommodative spasm lasts longer (six hours) than the mydriasis (four hours). This routine is used only when a glaucoma patient or a narrow angle patient has been dilated. (4) There is some evidence that angle closure glaucoma may in fact be precipitated by the use of miotics. (5) This may best be understood by thinking in terms of relative pupil block. (This occurs when the iris and the lens are close enough together as to interfere with the aqueous flow into the interior chamber. Due to this interference, the iris is bowed forward by increased pressure from within causing an angle closure.)
2. To treat angle closure glaucoma you have induced by dilation. If you are absolutely sure that you have an angle closure glaucoma, (the main signs are increased intraocular pressure, dilated pupil, hazy cornea, and a shallow interior chamber), call an ophthalmologist immediately. Do not instill Pilocarpine on your own. The routine ophthalmological treatment for angle closure glaucoma usually begins with the instillation of 4% or 6% Pilocarpine every five to ten minutes for the first half hour. Then one drop every one to two hours and other procedures if the attack has not been broken, as well as other medications, local and systemic.

I have presented a brief look at what I feel are good diagnostic drugs for optometric purposes. The main disadvantage for optometry has always been legislative restrictions and the fear of local reaction to these drugs. I have attempted to show that the possibility of local reaction is extremely remote. After having seen the use of local anesthetics discussed here in over 20,000 patients, I have yet to see any adverse reactions. I have seen the dilating agents discussed here in over 10,000 patients and likewise have seen no ill effects. (This includes not causing an angle closure glaucoma.) The study quoted earlier by Abraham in 1933 gives the incidence of angle closure glaucoma at 1:18,400. These statistics no doubt would show the incidence of this type of glaucoma to be even more remote if some simple angle evaluation procedures were used to screen out the narrow angles prior to dilation. These procedures would be taught in the clinical portion of pharmacology courses.

I have also attempted to show the need for us to use these agents in our routine office procedures. Since the risks are minimal, the advantages, in my opinion, far outweigh the disadvantages. We would be able to deliver even better eye health care with greater ease to all our patients. At present we should hesitate to use these drugs without proper courses in pharmacology at both the didactic and clinical levels. But, these educational requirements should be our only restrictions against the diagnostic use of these medications.

FOOTNOTES

1. Kolker, Allan and Hetherington, John, *Becker-Shaffer's Diagnosis and Therapy of the Glaucomas*, 3rd Edition, p 175.
2. Gorin and Posner, *Slit Lamp Gonioscopy*, 3rd Edition, p 54.
3. Unpublished personal observations.
4. Havener, William, *Ocular Pharmacology*, 3rd Edition, p 222.
5. Leopole, Irving, Ocular Therapy, Volume I, p 16.

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